INSTRUCTIONS

Please print all information

THANK YOU FOR CHOOSING OUR PLAN.

How to Fill Out This Form – Press Firmly – Please Use Ballpoint Pen

Please read these instructions before filling out the attached Enrollment and Membership Change Form. Here's what you neec to fill out, so we can enroll you without delay.

For membership changes, complete:
Section 1. "Tell Us About You"
Section 3. "Change Membership"
In addition, when adding/cancelling eligible dependents, or changing a Primary Care Physician (PCP), complete:
Section 6. "List Family Members"

1. Tell Us About You

Please complete all information in this section.

2. New Membership

Please check the appropriate box. If you are enrolling as a COBRA or C.G.S. 38a-538 extension of coverage member, please indicate the date of the Qualifying Event, and also the Reason Code.

REASON CODE	QUALIFYING EVENT	REASON CODE	QUALIFYING EVENT
01	Divorce	04	Dependent child no longer eligible under terms of employer's contract
02	Termination of employment	05	Reduction in hours/no longer meet group eligibility requirements
03	Spouse of deceased employee		

3. Change Membership

Please check the appropriate box if you are changing membership. Please indicate the reason and date. Some examples include:

ADDRESS	MARRIED	DEPENDENT
PCP	LEGALLY SEPARATED	BIRTH
NAME	DIVORCED	ADOPTION

4. Your Membership Choices

A. Tell us the plan name in which you are enrolling. To do this, check the appropriate box next to your selection choice(s). If you choose "BlueCare", "Dental", or "other", please be sure to write the name of the plan as instructed by your Benefits Coordinator.
B. Please check individual, two person or family for each plan choice.

5. Where You Work

Please complete all information in this section.

6. List Members To Be Added/Cancelled

A. Please be sure to complete all information in this section including social security numbers, and the name(s) of recognized institution(s) for full time student dependent(s) age 19 or over.
B. Indicate last name if different.
C. If any dependent(s) listed are disabled, please circle that dependent, and attach the appropriate application which may be obtained from your Benefits Coordinator.

D. Special instructions for BlueCare. A Primary Care Physician (PCP) must be selected for each member. Each member may choose a different PCP. Specialists cannot be selected as PCPs. Please also write in the city or town where the PCP's office is located, and the PCP provider number, located in your Provider Directory.

An asterisk (*) next to a Physician's name in the provider listing means the physician can only be seen by a current patient. If you are a current patient and want that physician to be your PCP, please check the box next to the physician's name on the application.

E. If coverage is available through your employer's plan for domestic partnerships, please include the appropriate certification forms.

7. Tell Us About Your Other Insurance

Please be sure to note any other insurance information in this section.

8. Medicare/Medicaid

Please complete all information in this section if you or an enrolled member is covered by Medicare or Medicaid, or have applied for Medicare or Medicaid disability.

9. Employee Signature

Please sign and return the completed application to your employer's Benefits Coordinator. Save your copy of this form for your records until you receive your identification card(s). A copy of this application is provided to you as part of your Subscriber Agreement or health benefit plan document as applicable and is incorporated by reference therein.

The definitions listed below are for informational purposes only. For additional information, please refer to your Master Group Policy, Subscriber Agreement, or the Evidence of Coverage.

DEFINITIONS

ELIGIBLE EMPLOYEE: An Eligible Employee is defined as a full-time employee of the employer. In order to qualify as a full-time employee, the employee must be actively at work and working at least 30 hours per week on a regularly scheduled basis unless a higher number of hours per week is required by the employer. Temporary employees and seasonal employees are not eligible for coverage.

ELIGIBLE DEPENDENTS: a. An Eligible Employee's spouse under a legally valid existing marriage,
b. An unmarried, dependent child of an Eligible Employee, to age 19, or an unmarried dependent child between the ages of 19 and 23 who is a full-time student at a recognized college, university or trade school. Child includes a natural child, a legally adopted child or a child legally placed for adoption, a step-child who lives with the employee, a child supported by the employee pursuant to a valid court order, or a child for whom the employee is legal guardian.

EXCEPTION FOR NEWBORN: Newborn children are automatically entitled to coverage for the first 31 days following birth. If no additional premium is due Anthem BCBS, a completed Enrollment and Membership Change Form must be submitted to Anthem BCBS within a reasonable amount of time following birth in order to continue coverage without interruption.
If additional premium is required, a completed Enrollment and Membership Change Form must be submitted to Anthem BCBS within 31 days following birth in order for coverage to be continued without interruption.

LATE ENROLLEE: An Eligible Employee and/or dependent who requests insurance more than 31 days after the employee's earliest opportunity to enroll for coverage under any plan sponsored by the Employer may be considered a late enrollee. A Late Enrollee will be subject to a 12 month pre-existing condition waiting period for indemnity/PPO plans, or a 3 month affiliation period for HMO plans. Late Enrollees who are eligible for coverage will not be denied coverage, and completion of a statement of health form may be required.

An Eligible Employee and/or dependent will not be considered a Late Enrollee, if a request for coverage is made and all of the following conditions satisfied: (1) Coverage was not elected when the employee was first eligible under the group policy solely because another group health insurance plan provided coverage for the employee; and (2) Coverage is lost under that plan due to employment termination, death of a spouse, divorce, legal separation, loss of eligibility, COBRA benefit is exhausted, reduction in the number of work hours for employment, or the employer stops contributing to the health benefit plan; and (3) The employee applies for coverage under this contract within 31 days after loss of coverage under the other plan.

ACTIVELY AT WORK: The term Actively At Work means the employee must: work at the employer group's place of business or at such place(s) as normal business requires; and perform all the duties of the job as required of a full-time employee working 30 or more hours per week on a regularly scheduled basis.

WAITING PERIOD: Means a period of time that must pass before an employee or a dependent is eligible to enroll in the plan. The Anthem BCBS standard waiting period allows for new hires to be eligible to enroll for coverage following 30 days of continuous "actively at work employment." Generally new hires and their dependents who apply for coverage more than 31 days from the date first eligible will be considered a Late Enrollee.

EFFECTIVE DATES: New hires and their dependents will be effective the first of the month following completion of the waiting period. Effective dates for new hires may be deferred if all required information is not received, or is incomplete.

***PRE-EXISTING CONDITION:** (Required for Small Employer Groups 1-50) The term Pre-Existing Condition means a condition, whether physical or mental, regardless of the cause of the condition, for which medical advice, care, or treatment was recommended or received within the Pre-Existing Condition Period as specified in the Schedule of Benefits.

***PRE-EXISTING CONDITION PERIOD:** A period of time immediately prior to the effective date of coverage.

AFFILIATION PERIOD: Means a period of time that must expire before health coverage provided by an HMO becomes effective and during which the HMO is not required to provide benefits. No premium shall be collected for such period.

BENEFITS EXCLUSION PERIOD: A period of time during which no benefits will be provided for a pre-existing condition. Prior creditable coverage can reduce the length of a benefit exclusion period. We will request a certificate of prior creditable coverage from you regarding your previous health plan if necessary.

OPEN ENROLLMENT PERIOD: The term open enrollment means the period of time during which an employer group allows employees to select group health coverage.

*These provisions are not applicable to HMO products.

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Membership Change Form

1. Tell Us About You

Current Anthem BCBS Contract Number, if any

Last Name | First Name | M.I.

Home Address: Number and Street or P.O. Box | Apt. #

City | State | Zip Code

Home Telephone ( ) | Work Telephone ( )

MARITAL STATUS ☐ Single ☐ Married ☐ Legally Separated ☐ Separated ☐ Widowed ☐ Divorced

2. New Membership

☐ NEW HIRE
☐ OPEN ENROLLMENT
☐ COBRA/C.G.S. 38a-538
DATE OF QUALIFYING EVENT ___/___/___
REASON ___ SEE INSTRUCTION SHEET
☐ NEW GROUP (ORIG ENROLLMENT)

3. Change Membership

CHANGE:
☐ ADDRESS
☐ NAME
☐ OTHER
REASON ___
DATE ___/___/___

To Be Completed By Employer

Requested Effective Date ___/___/___

Firm Division No.

Health Benefit Plan

For Office Use Only

4. Your Membership Choices

	Individual	Two Person	Family
☐ BLUECARE PLAN NAME	☐	☐	☐
☐ CENTURY PREFERRED/PPO	☐	☐	☐
☐ DENTAL PLAN NAME	☐	☐	☐
☐ HMO--NEW ENGLAND	☐	☐	☐
☐ OTHER PLAN NAME	☐	☐	☐

Are you or any other eligible dependent listed on this form currently confined to a hospital or other healthcare facility, totally disabled or physically impaired? ☐ YES ☐ NO

5. Where You Work

COMPANY NAME

ARE YOU ACTIVELY AT WORK? ☐ YES ☐ NO / (IF NO) REASON ☐ SICK ☐ INJURED ☐ OTHER

ARE YOU CURRENTLY CLAIMING WORKERS' COMP. MEDICAL BENEFITS? ☐ YES ☐ NO

DO YOU WORK 30 OR MORE HOURS PER WEEK? ☐ YES ☐ NO

DATE OF FULL TIME HIRE ___/___/___ | DATE OF PART TIME HIRE ___/___/___ | DATE OF REHIRE ___/___/___

6. List Members To Be Added/Cancelled

SEX	NAME (FIRST/MIDDLE/LAST NAME)	Add	Cancel	Social Security Number	Date of Birth (MM/DD/YYYY)	Full Time Student Age 19 or Over (Circle Yes or No)	BELOW PLEASE INDICATE NAME OF RECOGNIZED INSTITUTION FOR FULL TIME STUDENTS	Primary Care Physician (PCP) Name (Refer to Provider Directory or www.anthem.com) Check ☑ the box if you currently use this physician.
☐ M ☐ F	Self				/ /			Name PCP Provider No. ☐ City
☐ M ☐ F	Spouse				/ /			Name PCP Provider No. ☐ City
DEPENDENTS: Children over 19 may be eligible if disabled, or unmarried full-time students. Please circle disabled dependent.								
☐ M ☐ F	Dependent				/ /	Y N		Name PCP Provider No. ☐ City
☐ M ☐ F	Dependent				/ /	Y N		Name PCP Provider No. ☐ City
☐ M ☐ F	Dependent				/ /	Y N		Name PCP Provider No. ☐ City

7. Tell Us About Your Other Insurance

Do you or any other member of your family have any other medical, dental, or Anthem BCBS coverage? ☐ YES ☐ NO

If yes, please fill in the information below. ☐ Self ☐ Spouse ☐ Children

Name of Other Insurance Company	Name of Subscriber (Policyholder)	Policy or ID No.	Reason For Termination	First and Last Date of Coverage

8. Medicare/Medicaid

Do you or any covered member have Medicare/Medicaid coverage? ☐ YES ☐ NO

Have you or any covered member applied for Medicare/Medicaid disability? ☐ YES ☐ NO

Name (Self)	Are you actively at work?	Retirement Date	Name (Dependent)	Is this person actively at work?	Retirement Date
	☐ YES ☐ NO	___/___/___		☐ YES ☐ NO	___/___/___

Medicare No.	Medicare A (Hospital) Effective Dates	Medicare B (Medical)	Medicare No.	Medicare A (Hospital) Effective Dates	Medicare B (Medical)
	___/___/___	___/___/___		___/___/___	___/___/___

I understand that false and/or incomplete responses or statements may result in rescission of coverage and/or non-payment of claims for myself or my eligible dependents. I understand a copy of this application is provided to me as part of my Subscriber Agreement or health benefit plan document as applicable and is incorporated by reference therein. I certify that my statements in this form are true and complete to the best of my knowledge and belief.

9. Employee Signature

Date ___/___/___